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Outreach Rehabilitation Team: Expanding Rehabilitation Reach in Underserviced Areas

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Author: Emma Pettey, Senior Humanitarian Programme Officer, CBMG Humanitarian Technical Team.

Technical review and inputs:

- M. Shajjat Hossain, Rohingya Response Manager, CBMG, Bangladesh.
- Liton Paul, Programme Operation Manager, CDD
- Prosenjit Baidya, Manager-Rehabilitation, CDD
- Dr. Somen PALIT. Manager Health, IFRC
- Dr. Bayezeed Mostaque, Health & PSS Manager, Team Leader, IITC, PMO, BDRCS
- Md. Ariful Islam, Health & Environment Coordinator, BDRCS

Font cover caption: The Outreach Rehabilitation team provided services at the Field Hospital of Bangladesh Red Crescent Society (BDRCS), Ukhiya Upazila, Cox's Bazar. Mr. Md. Abdul Kuddus providing therapy services to Mr. Abdul Goni, FDMN Camp-18 referred by the camp-level primary health services provider.

Contents

Introduction

Since 25th August 2017, extreme violence in Rakhine state, Myanmar has driven over 859,000 refugees across the border into Cox's Bazar in Bangladesh.[1] Before they departed from Myanmar, people with disabilities received limited services with most never having received any sort of rehabilitation or psychosocial support in their lifetime and medical services being limited to traditional healers and village doctors. Many often experienced discrimination, stereotyping, or ignorance of service providers about their specific requirements.

In December 2017, based on the results of a rapid assessment[2] which was conducted with Arbeiter Samariter Bund (ASB), CBM and CDD established a comprehensive health and rehabilitation program focussed on providing accessible primary health care and rehabilitation services under one roof, with a Homebased Rehabilitation (HBR) team to reach persons who were unable to come to the health and rehabilitation centre.

Alongside this, an Age and Disability Working Group (ADWG)[3] under the leadership of CBM, CDD, Humanity & Inclusion (formerly Handicap International), and HelpAge International was established to promote the inclusion of persons with disabilities in the humanitarian response and ensure coordination among actors providing rehabilitation to prevent overlapping of services.

Findings of the service mapping conducted by the ADWG showed that even four years after the influx of the Rohingya people to Cox's Bazar and the establishment of services by humanitarian actors, significant gaps in rehabilitation services remained.

The Age and Disability Inclusion Needs Assessment[4] conducted by REACH identified the gaps in the quality of healthcare services in the Rohingya camps were identified, including a need for better access to treatment of disability-related health conditions was identified. There also seemed to be a perception that the forms of health treatment needed were unavailable and/or of low quality in camps, and that sometimes inadequate treatment was received.

The rapid Assistive Technology Assessment (rATA)[5] conducted by CBM Global and REACH in May 2021 identified that only one percent of people with disabilities in the Rohingya camps had their needs for assistive technology met, and 51 percent had unmet needs for assistive technology.

Demand to meet these gaps was placed on the ADWG, as many humanitarian organizations found that older persons and people with disabilities were unable to access humanitarian services and participate in community programs due to lack of rehabilitation and assistive devices. As most primary health care service providers did not include rehabilitation professionals as part of their teams, requests were also received from these organizations to support continuity of care through inpatient rehabilitation and safe discharge planning following surgeries and other medical treatment.

As the context of the Rohingya crisis evolved, CBM and CDD determined there was a need to have a mid to long term perspective around both how

rehabilitation services should be delivered and at the same time how the highest needs can be met with limited resources.

Supported by the New Zealand Aid Programme, CBM and CDD decided to pilot a new approach to reaching underserviced populations through the "Outreach Rehabilitation Team" model.

The piloting of this approach has caused a prompted in rehabilitation service provision through a more collaborative, community based approach that is suited in these settings. This model has allowed for meeting both the greatest needs and reaching people in areas who previously had no (or limited) access to rehabilitation services.

The Pilot Model

An initial partnership was established with the Bangladesh Red Crescent Society whereby rehabilitation services were provided at BDRCS' field hospital.

The rehabilitation team consisted of the following professionals:

- Physiotherapist
- Occupational Therapist
- Speech and Language Therapist
- Therapy Assistant

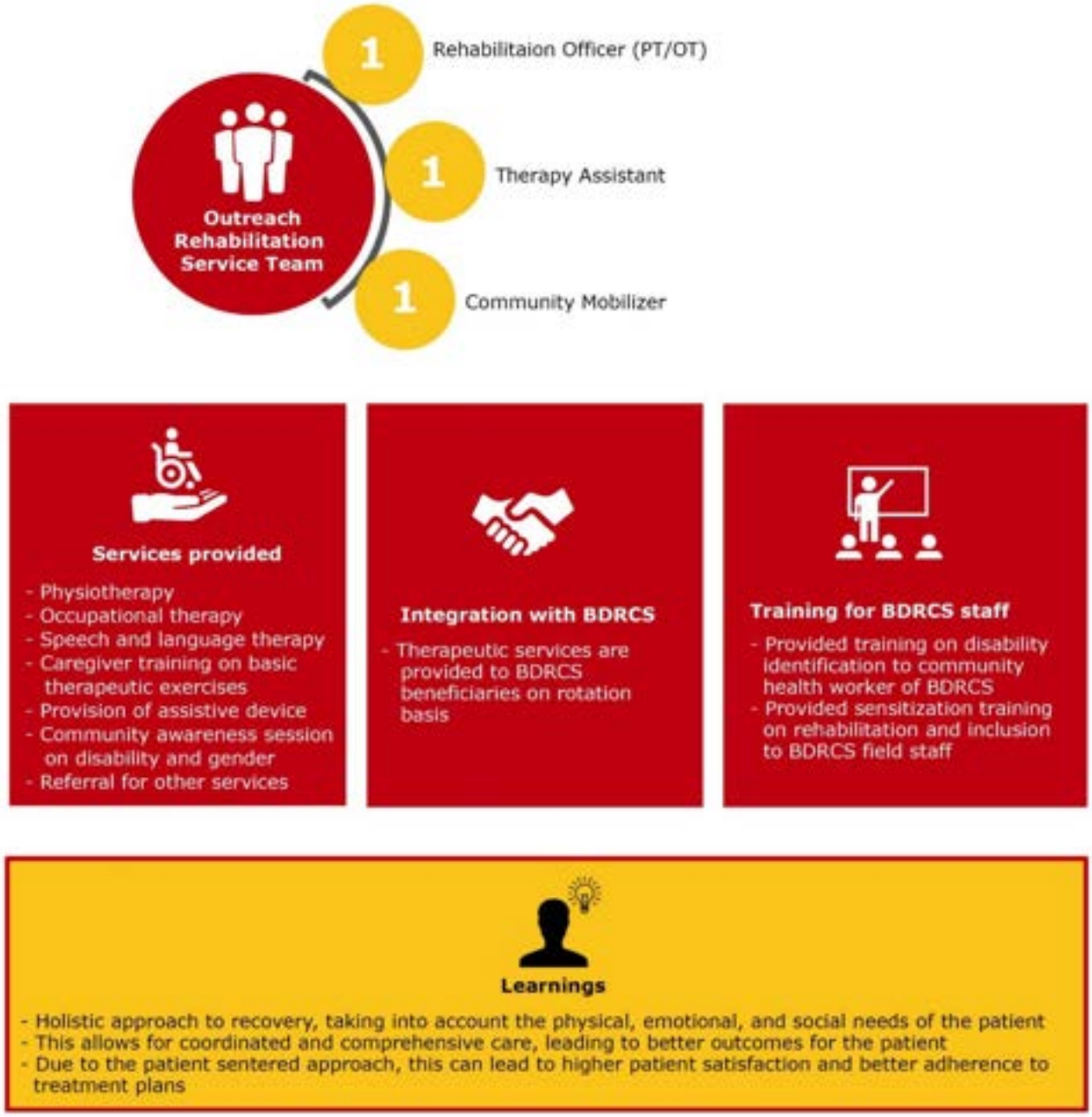
The therapy team provided the following services:

- Physical rehabilitation
- Assessment for and provision of assistive devices and training on use
- Caregiver training

The team was integrated into the BDRCS field hospital health care team, and provided services under a separate shade on the grounds of the field hospital. The team was present in the hospital two days per week. Due to the fact that clients were coming from different areas of the camp, rehabilitation services were only conducted in the field hospital and not at client's homes. Referrals to the rehabilitation team were made through both the BDRCS registration desk and from the BDRCS doctors. If the registration desk officer found a client experiencing pain or paralysis, they would refer directly to the CBMG-CDD team. Likewise, if any of the doctors during their client exam found a client in need of rehabilitation, they referred to CBMG-CDD. Referrals were made using either a referral form or verbally.

CBMG-CDD therapists also initiated referrals to medical services for clients who were receiving rehabilitation services and who needed other primary healthcare services.

A one day training was provided to BDRCS field hospital staff at the start of the partnership. This training covered both an introduction to disability inclusion and rehabilitation focusing on the importance of rehabilitation services in primary health care and how to identify clients in need of refer to rehabilitation.



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Learnings From Practice

Learning #1: A Rehabilitation Team Working in Partnership with Primary Health Care Providers Provides More Comprehensive Healthcare

WHO states that a multidisciplinary workforce in health systems ensures that the range of rehabilitation needs within a population can be met. Multidisciplinary rehabilitation interventions have been shown to be effective in the management of many chronic, complex or severe conditions that may significantly impact multiple domains of functioning (vision, communication, mobility and cognition). As different rehabilitation disciplines require specific skills, a multidisciplinary workforce can significantly improve quality of care and improve health outcomes.

The integration of rehabilitation into primary health care can optimize outcomes of other health interventions, and prevent or manage complications associated with other health conditions. As the time between medical intervention and provision of rehabilitation increases, conditions become more chronic and prognosis generally deteriorates. Lack of early rehabilitation puts a person at risk of developing further complications and negatively affects longer term prognosis, with the health needs of persons with chronic conditions unlikely to be effectively addressed without rehabilitation. By having CBMG and CDD's therapists present at the BDRCS field hospital allowed for clients to have their health care and rehabilitation needs met in one location. This helped prevent people from "slipping through the cracks" and being discharged following hospitalization without necessary rehabilitation.

"Having both medical and rehabilitative care at the same time allows the patient to recover faster". Dr. Shaila Akter, Medical Officer, BDRCS

Initially the CBMG-CDD was receiving a very limited number of referrals from the registration desk and doctors. However, after the BDRCS team saw the effectiveness of rehabilitation of client's functional outcomes and positive outcomes of referring clients to the rehabilitation team, the team saw a three fold increase in referrals.

Effective communication between professionals in a multidisciplinary team is crucial to ensure quality of care, but high caseloads and time constraints can cause challenges for team members to discuss every case with other health professionals on the client's team. Having the rehabilitation team on site helped improve interdisciplinary communication as the referring practitioner could discuss directly with the therapy team.

One of the critical factors in determining whether CBMG and CDD would respond to a referral through the ADWG was the referring agency. In order to promote continuity of care and follow up with clients even when the CBMG CDD team was not present, CBMG and CDD only accepted referrals from health actors.

"My condition has improved a lot through receiving timely medical treatment, as well as the use of the assistive medical devices, both of which, I believe, have improved my physical condition" Mr. Samso, CBMG and CDD's project participant.

Learning #2: In Underserviced Areas, Outreach Teams Provide Access to Rehabilitation which would Otherwise be Inaccessible

In the context of the Rohingya camps and host community, the need and demand for rehabilitation services is significantly higher than the availability of services.

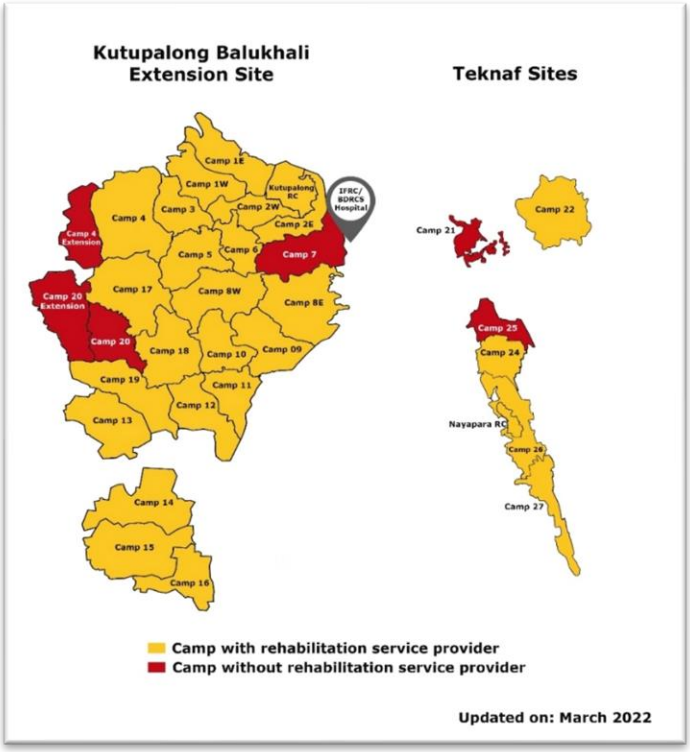
One of the criteria for the outreach rehabilitation team to provide services was that no other rehabilitation actor was present in that operating area. The service mapping completed by the ADWG was one tool used by CBMG and CDD in deciding if they would respond to a request for rehabilitation services in a given area.

The CBMG-CDD team had found that in their regular coverage areas, where services were provided through fixed health centres and homebased rehabilitation teams, they were able to provide more comprehensive services to clients. However, in a context whereby the need for rehabilitation services significantly outweighs the resources available, there is a need to triage and ensure that the people with the most pressing needs and urgent cases are able to have their rehabilitation needs met.

The outreach service model allowed for people in need of rehabilitation services in camps which were unreached by rehabilitation service providers to access such services. By providing training to healthcare workers at the BDRCS field hospital, follow ups could be provided by the BDRCS team thereby freeing up time for the CBMG-CDD rehabilitation team to see more clients.

Part of CBMG-CDD's homebased rehabilitation model is to provide information raising on available rehabilitation services. By providing services at BDRCS's field hospital, the BDRCS team also made client's aware of the rehabilitation services provided by CBMG-CDD, thus providing information on available rehabilitation services these client's may not otherwise have had.

Relying on the established infrastructure of an existing health actor allowed CBMG-CDD to move into new areas of the camp in a cost effective manner to provide integrated services.



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Learning #3: Systematic Change Takes Time and Buy In at Multiple Levels

Over the course of the engagement between BDRCS and CBMG-CDD, improvements were made to make services more disability inclusive. In addition to services being provided at the field hospital, community workers were also providing more services in client's homes in the community. With the technical support from the CBMG-CDD team, BDRCS also made some modifications to make their pathways throughout the hospital more accessible.

While the CBMG-CDD team had been present at the BDRCS field hospital for over a year, the rehabilitation service provision was solely overseen and provided by the CBMG-CDD team. Follow up on rehabilitation services remained within the remit of the CBMG-CDD team, and was only available the two days the team was at the hospital. An initial training around the importance of rehabilitation service provision and referrals was provided to the registration officers and doctors, however, a more systematic training curriculum with buy in from the staff would have been needed in order for more skills transfer to happen for BDRCS' medical team and health officers to be able to provide some basic rehabilitation services and follow ups. Capacity building of other health staff can help to improve continuity of care, especially when rehabilitation professionals may be rotating and not in the clinic on a daily basis.

Creating systematic change to integrate rehabilitation into the primary health provision of an organization requires commitment across all levels of the organization. Funding for the CBMG-CDD rehabilitation team was secured entirely by CBMG-CDD, with these services being dependent on CBMG-CDD being able to secure funding for the positions. While both organizations were agreeable to pursuing joint funding opportunities which could fund the rehabilitation work within the BDRCS field hospital, these opportunities did not materialize during the engagement together. Funding needs to be considered and secured for all key roles and services, including rehabilitation service provision.

While the CBMG-CDD team provided services at the BDRCS field hospital they were not integrated into the hospital management structure and were seen as a service provided by an external agency. While having the therapists present on site helped to meet a critical gap in rehabilitation service provision at the field hospital, a more ideal model would see rehabilitation services integrated within the primary health care structure of the hospital which could promote smoother referral systems and longevity.

Next Phase: Moving Forward After the Pilot

Services at the BDRCS field hospital will be decreasing in coming years as less clients come to the facility due to other health facilities within the camp providing the same services which are easier for the Rohingya people to access. At the same, requests for rehabilitation services including assistive device provision are continuously being brought to the Age and Disability Working Group.

During the pilot phase, CBMG-CDD also responded to some ad-hoc requests from other agencies to provide rehabilitation services including the provision of assistive devices for their beneficiaries. The next phase will respond to providing services at the location of other organizations in the form of "camps", whereby the therapy team will travel to the referring organizations site for three to five days. During this period, clients will be assessed and fitted for assistive devices. Client and caregiver training will be incorporated within the camps.

Learnings from the pilot phase have been incorporated into the design of the next phase and will continue to be collected. Similar to the services provided under the pilot phase, this model should allow CBMG-CDD to reach people who would otherwise not have access to rehabilitation services. A stronger capacity-building component will be built into the next phase, with an emphasis on job coaching and mentoring for the staff of the referring agencies on the use of the assistive devices and how to support the client in using them. As the model is entirely dependent on referrals being managed by the referring organization, training on when to refer back to CBMG-CDD for reassessment or further support will be provided and uptake monitored.

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For more information, please contact:

Centre for Disability in Development (CDD)
A-18/6, Genda, Savar Dhaka
Contact: 01713021695, 01711538021
Email: info@cdd.org.bd
Web: https://cdd.org.bd/

CBM Global Disability Inclusion
House: 59, Apartment: A-1, Road: 01,
Block: I, Banani, Dhaka-1213, Bangladesh.
Tel (Office): +8802222270707
Emergency Cell: +8801979707770
E-mail: info.bangladesh@cbm-global.org
www.cbm-global.org

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